Chief Coroner

REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

1.	**CORONER** I am Penelope SCHOFIELD, Senior Coroner, for the coroner area of West Sussex, Brighton and Hove.
2.	**DATE OF REPORT** 07 July 2026
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4.	**THIS REPORT IS BEING SENT TO** 1. **The Chief Executive, University Hospitals Sussex NHS Foundation Trust** 2. **The Chief Executive Royal Surrey NHS Foundation Trust** You are under a duty to respond to this report within 56 days of the date of this report, namely by August 31, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6.	**SUMMARY OF CORONER'S CONCERN** The Inquest revealed that there were confused lines of communication between Clinicians at the University Hospitals Sussex NHS Foundation Trust

	and the Hepato-Pancreato-Biliary. department at the Royal Surrey NHS Foundation Trust when dealing with acutely unwell patients on the Intensive Care Unit. Whilst this was not a causative feature in this case it does present a risk to the care provided to future patients.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 08 July 2024 I commenced an investigation into the death of Gemma Louise ROBINS aged 30. The investigation concluded at the end of the inquest on 06 July 2026. The conclusion of the inquest was that: Gemma died from natural causes however there was a missed opportunity at her antenatal appointment on 23rd April 2024 to investigate possible pre-eclampsia. Blood tests may have revealed abnormal liver function tests which in turn may have led to an earlier admission to hospital. However, it is not possible to say whether this would have prevented Gemma's death.
9.	**CIRCUMSTANCES OF DEATH** On 25th April 2024 Gemma, who was in her third trimester of pregnancy, was admitted to Worthing Hospital following persistent vomiting and an inability to keep food or fluids down since the afternoon 23rd April 2024. She had had an antenatal appointment earlier that day. On admission on 25th April 2024 Gemma was acutely unwell and a decision was made for her to have an emergency caesarean. Her daughter was born at 6:47 hours. Gemma remained unwell following the birth and despite treatment over a period of 40 days on intensive care she did not recover and sadly died on 13th June 2024.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: Whilst it is appreciated that communication is difficult when so many different specialist clinicians are involved in a patient's care particularly when on the Intensive Care Unit.

	At the time of Gemma's death clinicians communicated via text, email and telephone to discuss patient care. I heard that these modes of communication can be extremely challenging and prone to miscommunication when multiple teams were involved with a patient. Although some improvements have been made the Court's Expert witness indicated that these issues will continue to occur unless there is one centralised system/platform which clinicians across both NHS Trusts have access to and facilitates the use real time recording of communications.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. **The Family of Gemma Robins** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Penelope SCHOFIELD** **Senior Coroner for** **West Sussex, Brighton and Hove**